

TRANSCRIPT REQUEST

PLEASE PRINT CLEARLY

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Requested By: Last :		First:		Date of Birth:
Requester's Address:				E-Mail:
City:	State:	Zip Code:		Telphone Number:
Name at time of Gradua	າ:		Class of:	
Check One: Current Student Graduate Resigned - Date				
Current Employer:				
Purpose of Request: Personal Employment College/University Scholarship				
Current Employer:				
 PAYMENT; (Fee may change without notice). Regular: \$3.00 per copy (within 10 business days). Express: \$10.00 (1-2 business days) Payable to the Los Angeles County College of Nursing and Allied Health. Payment (check or money order) for transcripts must accompany request. Transcript requested in person: Submit payment at any LAC+USC Medical Center's Cashier Office, bring receipt and transcript request form to the College. Delivery: Pick Up Number of transcripts to be picked up:				
To:			•	
-				B Regular (\$3.00) (each)
City:		State:	Zip:	Regular (\$3.00) (each) Rush (\$10.00) (order) 1-2 business days.
signature: Date:				ate:
Transcripts will NOT be processed without the signature of the requester nor if requester has outstanding Financial Obligations.				
For Office Use Only:				
Transcript Receipt Nu	mber:	Sign	Amo	ount Paid
- Mailed	Date.		ad Dec	